

Doctors who cause the patient deaths

Case note on *S v McGown* 1995 (1) ZLR 4 (H)

Introduction

There are relatively few cases of medical negligence that have been decided by our courts and even fewer cases where medical practitioners have been convicted of criminal offences for negligently causing the deaths of their patients. When things go wrong during or after medical procedures and the patients end up dying, there must be a proper investigation to determine the cause of the death and whether the medical practitioners should be held legally responsible for the deaths.

The *McGown* case sets out the test used to determine whether a specialist doctor, in this case, an anaesthetist, is to be held criminally responsible for negligently causing the death of his or her patient. The court had to decide two main issues in this case. The first was whether the accused was negligent in administering for post-operative pain an excessive dosage of epidural morphine together with other drugs. The second was whether, in the light of the increased post-operative risks emanating from the anaesthetic process he had chosen to use, he had been negligent in failing to ensure appropriate post-operative care for his patients. In reaching its conclusions on these matters the court was guided by a whole array of expert testimony from medical specialists.

The test for negligence

A person is guilty of culpable homicide when he or she negligently causing the death of a person. The general test for negligence is whether a reasonable person would have foreseen that his or her actions would result in the death and, having foreseen death, would have taken reasonable steps to avoid the death.

Put in the medical context, the test for negligence is whether the medical practitioner failed to exercise the degree of skill and care which would have been exercised in those circumstances by reasonable medical practitioners. This applies to all stages of medical procedures: diagnosis, administration of drugs, surgical intervention and post-operative care.

When dealing with a specialist medical practitioner, the test for negligence is whether the specialist failed to exercise the degree of skill and care that would reasonably be expected by a reasonable specialist in that field.

As judges do not have expertise in the field of medicine, they largely depend upon expert medical opinion to determine the appropriate standard of reasonable skill and care to be used to measure the conduct of the medical practitioner in question. The courts have laid down that the test to be applied does not demand that the medical practitioner need not possess the highest degree of expert skill but only that would be exercised by an ordinary competent member of that profession. The courts have also stressed that not every slip or mishap during a medical procedure will constitute negligence; it will only be treated as negligence if it would not have happened if the medical practitioner had used reasonable skill and care. If it would have occurred even if a medical practitioner was exercising reasonable skill it would be an excusable error or mishap.

One way of testing whether a medical practitioner has been negligent is to examine whether he or she had deviated from a generally accepted and approved procedure for dealing with that medical situation for no reasonably justifiable reason.¹ But the failure to use the standard procedure will only be deemed to be negligent if no reasonably competent medical practitioner would adopt that course of action. The courts have accepted that it is in the public interest that new forms of medical procedures should be developed and such development should not be stifled. But medical practitioners must not engage in procedures which are known to create significant and serious risks. It is different if one medical expert testifies that the medical practitioner acted negligently and another expert disagrees and testifies that he did not act negligently.

The practice of medicine does not stand still and advances and improvement are constantly being made. New or more effective medical procedures are being developed and new or more effective drugs become available to medical practitioners. Medical research may also highlight the risks attaching to certain medical procedures that were previously not appreciated. Medical practitioners are expected to keep reasonably abreast of major developments that have occurred in the medical field that are reported and commented upon in medical journals and in the press.²

When a case of medical negligence comes before a court, the case can only be determined in accordance with the state of medical knowledge at the time the medical event in question occurred. This is illustrated by the English case of *Roe v Ministry of Health* [1954] 2 QB 85. The doctors had been storing glass ampoules containing medicines in a sterile liquid. It was not known to medical science at the time that the glass ampoules could develop hairline cracks and that the sterile liquid could seep through the cracks and contaminate the medicine inside the ampoules. The doctors used the medicine inside the ampoules on patients not knowing it had been contaminated with disastrous health consequences. The doctors were found not guilty of negligence but subsequently there was extensive publicity about this and it would have been negligent thereafter to fail to advert to this danger and avoid it.

Anaesthetists are specialist doctors whose conduct will be tested against the standard of how a reasonable medical practitioner carrying medical practice in this specialty would have performed the specialist work in question. The South African case of *S v Kramer* 1987 (1) SA 887 (W) is instructive on the application of the appropriate standard of care. In this case there was an operation for removal of tonsils\adenoids in a healthy 10-year old girl. A relatively inexperienced anaesthetist placed the tube in the oesophagus instead of the trachea. The patient started bleeding excessively, displayed signs of lack of oxygen and of waking. The surgeon nevertheless completed the removal of a tonsil and replaced the incorrectly inserted tube. The patient again displayed signs of lack of oxygen and died in theatre. The court held that in general neither a surgeon nor the anaesthetist is liable for the other's negligence. They are not the agents of one another. They are not employed and controlled by one another. Each one

¹ But if it is widely accepted in medical practice that there are two alternate acceptable procedures that may be used, the medical practitioner is quite entitled to choose which of the two he or she will adopt.

² The court in the *McGown* case also pointed out that as medical practitioners are answerable for their conduct to the Medical Council, the Council should be aware of new techniques being used by medical practitioners, the risks that they entail and whether there are adequate facilities to accommodate their safe use. The Council should play a role in appraising medical practitioners about these matters.

performs a specific specialised function as part of a team consisting of surgeon, anaesthetist and nursing staff.

The court held that there was no duty on the surgeon either to check that the anaesthetist had correctly placed the tube or to look down the trachea of the deceased to check the position of the tube before commencing the operation. Accordingly, that the State had failed to prove that the surgeon was negligent at all and that he had been wrongly convicted of culpable homicide. The anaesthetist was the person who must and should be able to detect an incorrectly placed tube and he could be faulted for his failure to monitor the deceased properly and thereby detect the misplacement of the tube timeously. He had been correctly convicted of culpable homicide.

Charges against McGown

In this case an anaesthetist was charged with five counts of culpable homicide. He was convicted on two of these counts and acquitted on the other three counts. The two convictions related to the deaths of two children due to post-operative complications. In the first case a child aged two years was admitted to hospital to undergo a routine circumcision operation under general anaesthesia. After the operation the accused administered 1.25 mg of morphine caudally to the child together with adrenalin and lignocaine to control post-operative pain. The accused then discharged the child into the custody of his parents. The child died that night. The child's respiration had been depressed due to the morphine and the other drugs. The child had vomited and because his reflexes were also depressed, he was not able to eject the vomit from his airway. He died from asphyxia.

In the second case McGown administered 4 mg of morphine together with adrenalin and lignocaine to a child aged ten who had undergone appendectomy surgery under general anaesthesia. After the operation the accused discharged the boy into a general ward. He died that night due to respiratory depression due to the combined effects of the general anaesthesia and the drugs administered epidurally to relieve post-operative pain.

The first issue in both cases was whether the accused was negligent in using morphine epidurals for the control of post-operative pain. On the basis of the medical evidence, the court found that the use of epidural morphine is now an acceptable medical procedure and it is a very effective analgesic for controlling post-operative pain. However, the medical evidence also showed that its use created considerable risks of complications such as respiratory depression, reflex depression and vomiting and these complications could result in death. The larger the dose of morphine used the greater were the risks of post-operation complications. The risks are even greater if used in young children as the respiratory centres of their brains are not well developed and are more sensitive to the effects of morphine. The risks are also greater when morphine was used together with adrenaline and ligocaine.

The court pointed out that there was divided medical opinion as to whether morphine should be used by anaesthetists, some believing that it should not be administered as its disadvantages outweighed its advantages and safer drugs are available. Others continue to use it. Some of the medical experts testified that epidural morphine should not be used on young children and there were alternative drugs that could have been used in respect of simple operations such as circumcision or appendectomy. All the medical experts agreed however that the amounts of

morphine used in the two operations was too high, particularly the dosage for the 10 year old boy.

Nonetheless the court found, on the basis of the medical testimony, that it was not in itself “wrong” for the accused to have administered epidural morphine even to a young child. It is arguable that the accused could have been found guilty of negligence in using this procedure he choose to use. On the basis of the medical evidence, the risks attached to the epidural administration of a high dosage of morphine on children were such that a reasonable anaesthetist would have employed a far less risky alternative in the circumstances. The procedure in question created a reasonably foreseeable risk of death and the unreasonable procedure used was the cause of death. This view gains support from the finding of the court relating to the issue of whether the accused’s procedure fell within the ambit of a clinical trial. The court left open whether the process amounted to a clinical trial and was therefore experimental by the strict regulations governing clinical trials.³ In this regard it had this to say:

“... what is clear is that, when he started administering epidural morphine to children, there was no precedent. There were no recommended doses and the effects or risks were unknown. We agree with the *Attorney-General’s* statement that the accused set sail on unchartered waters without knowing what was to come of this technique. Whether this amounted to a clinical trial or experimentation is a matter that cannot be determined in the absence of further evidence.”

The court’s finding that the accused was guilty of culpable homicide was on the basis that the accused failed to ensure proper post-operative care. It said that all the medical experts agreed that the risks attaching to the anaesthetic process employed on the two children made it imperative that the children be under appropriate medical surveillance in hospital for twenty-four hours after their operations. Either the children should have been in a high care ward which was available at the hospital or in a general ward in which the nurses had been specially trained to monitor the children and to be able to respond properly to any complications that could arise from the procedure.

In respect of the child who was circumcised, the accused was guilty of gross negligence. After the child had been in recovery for only two minutes, he had released the child into the custody of the parents who had taken him home. It was reasonably foreseeable that the child would die if complications arose as the parents would be completely unable to cope with the situation.

In respect of the situation of the child who had had an appendectomy, the child was admitted into a general ward in which a single nurse had to attend to ten child patients in the ward. The accused was negligent in discharging the child into this ward where proper post-operative facilities were not available whereas he could have discharged the child into the high care ward which was available at the hospital. He failed to ascertain what facilities were available and he was negligent in not checking that the facilities in the general ward were adequate. His negligence was compounded by the accused giving the nurse inadequate and misleading instructions as to how to deal with the patient which she had followed. The court did not accept that the nurse had herself been negligent in the way in which she had responded when the complications arose but, even if she had been negligent in failing to call for help immediately, it

³ See Part III of the Medical And Allied Substances Control Act [Chapter 15:03]

was reasonably foreseeable that she would not be able to cope and any negligence on her part did not break the causal link between the accused's negligence and the death of the child.⁴

Conclusion

Our courts will not readily find a medical practitioner guilty of criminal negligence but blatant negligence will attract criminal consequences. A medical practitioner should not adopt an untested procedure that carries serious post-operative risks to the patient. But even if the court decides that it was not impermissible to utilize the procedure in question if that procedure may lead to post-operative complications, the medical practitioner is certainly obliged to ensure that the patient is kept under proper post-operative medical observation with adequate facilities to respond to any complications that may arise. In dealing with a case such as the present one the court will be guided to its conclusion by expert medical testimony.

⁴ A nurse may sometimes be unfairly blamed for a death of a patient when the medical practitioner has caused the death by his or her incompetent medical intervention or by failure to render appropriate post-operative care. The nurse should be found to have caused death to a post-operative patient if, for instance, contrary to the medical practitioner's clear instructions, she administers a wrong drug or a wrong dosage of the drug and this mistake results in the death of the patient.